



RENEWAL APPLICATION PROFESSIONAL EMPLOYER ORGANIZATION

Full name of applicant:		FEIN#:	
DBA name(s) of applicant:			
Principle business location (street, city, state, ZIP code):			
Address of each Indiana office (street, city, state, ZIP code):			
Contact person:		Title	Telephone number ()
Email Address:		Website Address:	
Is the applicant sponsoring a health plan? Yes No If yes, is the plan fully insured? Yes No If the plan is fully insured, provide: i. Name of insurance company _____ ii. Name of producer _____ iii. Term and effective date of coverage _____			
Has there been any adverse regulatory action taken by any state or federal regulatory law enforcement or regulatory agency against the PEO? Yes No If yes, please provide a detailed explanation and any documentation pertaining to the action.			
The following attachments must accompany this application:			
1. Copies of the applicant's articles of incorporation or other business organization documents, if modified during last year.			
2. a. Fully insured applicants must provide evidence of minimum net worth of \$50,000 or a statutory deposit of \$50,000, b. Self insured applicants must provide evidence of minimum net worth of \$50,000 and a fidelity bond in the greater of: i. 10% of premiums and contributions received by the health benefit plan; or ii. 10% of the claims paid.			
3. Copy of applicant's most recent financial statement prepared on a GAAP basis: a. reviewed by an independent CPA for a fully insured plan, licensed to practice in jurisdiction in which accountant is located, or b. audited by an independent CPA for a plan that is not fully insured.			
4. If applicant is offering a health plan that is not fully insured, must provide documentation of stop loss insurance with an insurer authorized to do business in Indiana with an aggregate retention of not more than 125% of the amount of expected claims.			
5. Documentation that contributions are set to fund 100% of the aggregate retention plus all other costs of the applicant. The funds held by the applicant for the health benefit plan must be held in a segregated trust account and may be used only for claims and administrative expenses of the health plan.			
6. The PEO applicant shall submit: a. an annual actuarial opinion from a qualified actuary, b. name of administrator licensed under IC 27-1-25, c. a written plan for handling claims, including services of its administrator, if modified during last year. d. a written plan acceptable to the commissioner for the payment of claims in the event of a voluntary dissolution or insolvency, if modified during last year.			
7. a. Fully insured applicants must provide resumes of any new individual who serves as president, chief executive officer, or otherwise has the authority to act as senior executive officer of the applicant, or b. Self insured applicants must provide NAIC Biographical Affidavits for each new person with the authority to make decisions or handle funds for the health benefit plan.			
8. Renewal fee of two hundred fifty dollars (\$250).			
9. Provide a listing of applicant's Indiana clients.			
10. List each person that individually or acting in concert with one or more other persons, owns or controls, directly or indirectly, 25% or more of the equity interests of the applicant. (If additional space is needed attach a separate sheet)			
Name		Title	Percentage of Ownership
I certify that there <input type="checkbox"/> have been no changes to any application information and documentation submitted during the last year; or I certify that there <input type="checkbox"/> have been changes to the previously submitted application information and the revised documentation is attached.			
Signature		Date	Printed Name Title